TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name**
BRYCE I. BENBOW, DO

**Respondent Name**
LIBERTY INSURANCE CORP

**MFDR Tracking Number**
M4-16-2854-01

**Carrier's Austin Representative**
Box Number 01

**MFDR Date Received**
MAY 17, 2016

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "it is our position that the denial is incorrect."

**Amount in Dispute:** $6,904.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Codes 64493-50, 64494-50, and 64495-50 were denied for incorrect coding."

**Response Submitted By:** Liberty Mutual Insurance Co.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| May 5, 2015 | CPT Codes 64493-50, 64494-50 and 64495-50 | $6,904.00 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The disputed services were reduced/denied by the respondent with the following reason codes:
   - X047-An incorrect combination of CPT codes has been billed. For reconsideration please submit appeal with EOP and the correct combination of codes.
   - W3, Additional payment made on appeal/reconsideration.
   - 193-Original payment decision is being maintained, upon review it was determined that this claim was processed properly.
   - X598-Claim has been re-evaluated based on additional documentation submitted; no additional payment due.

**Issue**

Did the requestor waive the right to medical fee dispute resolution?

**Findings**

28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of service in dispute is May 5, 2015. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on May 17, 2016. This date is later than one year after the date of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | 06/09/2016<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.